ROYAL PHARMACEUTICAL SOCIETY
England

66–68 East Smithfield
London E1W 1AW

Patron: Her Majesty The Queen
Chief Executive: Paul Bennett

Sustainability & Transformation Partnerships

NOVEMBER 2017

Dear STP lead,

- **Pharmacists can help solve a whole range of issues including better use of scarce resources, optimising the use of medicines, improving patient care and improving flow through the system.**
- **Your STP will be considering how they can mitigate the workforce challenges you face. Pharmacists are a growing part of the solution to workforce challenges.**
- **Pharmacists are the third biggest healthcare profession and are experts in the use of medicines, the most common health care intervention in every STP.**
- **Supporting the better use of medicines reduces costs and improves quality of care and pharmacists are key to this.**
- **Medicines are part of every patient pathway and pharmacists should be involved in the planning and implementation of STPs at an early stage.**

Many STPs across the country are defining how the health and social care system can work more efficiently. As part of this STPs are focusing on how they can improve patient flow through the system, ensuring that when patients require secondary care interventions, they can be discharged safely and in a timely manner back to their home or intermediate care. Pharmacists can support the discharge process but can also help with designing and delivering pathways and reducing medication errors. Pharmacists can support you in making your whole system more efficient.

Pharmacists, as experts in medicines and their use, have a key role in designing and delivering care pathways and improving patient flow as medicines are often one of the critical areas of care that can delay a patient's discharge. Pharmacists should be part of a multidisciplinary team that delivers interventions to improve patient flow through the system and we have highlighted (over the page) some examples where this is already happening in practice.

Making best use of and ensuring you get the best value from medicines will be a key aim of your STP; medicines are one of the biggest investments in any STP budget. Medicines transform people's lives and support the NHS to deliver within the funding available, they are not simply a cost that needs reducing. Investment in pharmacy and medicines optimisation early on in pathways can reduce costs further down the line, such as costs of readmissions due to inappropriate use of medicines or their side effects. Many medicines offer transformational treatment options for long term conditions such as medicines for HIV, Anti-TNF and Hepatitis C treatments. In addition pharmacy teams have developed innovative and new ways of working. With the strong existing primary and secondary care professional network, pharmacy teams share best practice and learning from previous experiences which in turn helps to enable system wide change. Many pharmacists working in hospital are qualified prescribers and can prescribe throughout the patient's journey within the hospital.

ROYAL
PHARMACEUTICAL
SOCIETY
England

All acute hospital trusts in England have developed and submitted Hospital Pharmacy Transformation Plans to NHS Improvement as part of the Carter work. The plans outline how to best utilise the pharmacy workforce within hospitals to improve care for patients by focusing on the optimisation of medicines, ensuring medicines are used safely and making the flow through the system more efficient. Progress against these Hospital Transformation Plans may be of interest to STPs. Hospital pharmacists are starting to work more closely with their colleagues in GP practices and community pharmacies to provide outreach services and specialist advice.

For your STP to realise the benefits that better utilisation of pharmacists can bring and to improve medicines optimisation, it is important for pharmacists to be brought into the development of implementation plans and working groups. Pharmacists' unique skills will enable you and your colleagues to identify where pharmacists can add value to every step of the pathway. Pharmacists will also see solutions to some of the issues you are facing and help you unblock some of these. True transformation of local services will not be possible without the use of all of the skills you have available to you and pharmacists are key to this.

The Royal Pharmaceutical Society (RPS) urges you to consider how you can best involve pharmacists in your STP so that you can benefit from the value they bring now and the opportunities for better quality they can provide in the future.

Across the country there are Local Professional Networks for Pharmacy which are tasked with supporting the STPs. The Local Pharmacy Networks will be happy to assist the implementation of STPs at a local level and more information and contact details can be found at https://www.england.nhs.uk/commissioning/primary-care-comm/lpn/lpn-contacts/

The RPS will be delighted to hear from STPs who already have pharmacists involved and we can help you share this best practice.

Yours sincerely,

Robbie Turner
Director for England

ROYAL PHARMACEUTICAL SOCIETY
England

Sustainability & Transformation Partnerships

NOVEMBER 2017

A crucial part of creating a sustainable NHS is to ensure that resources and professionals are being used to optimum capacity and in ways that have the greatest impact on patients.

Here are some examples of what pharmacists are already doing within secondary care and there will be many others yet to be developed.

1. Support and improve the delivery of urgent and emergency care by involving pharmacists in Emergency Departments

WHAT IS THE CHALLENGE?
Demand in Emergency Departments (ED) is increasing and the clinicians working in these departments are under pressure.

WHAT CAN BE DONE?
Utilising pharmacists in EDs can reduce pressure on other clinicians and improve quality outcomes for patients.

WHAT ARE THE RESULTS?
In Cambridge University Hospitals' Foundation Trust an investment in a pharmacy service (1WTE band 7 Pharmacist and 1WTE band 6 Pharmacy Technician) cost £81,053. Doctor time saved over the year has resulted in an estimated saving of £40,574 and dispensing avoidance and savings associated with use of patients' own medication has resulted in £83,720-£155,480 per year. There was also a 55% reduction in calls from ED to the on-call pharmacist from June/July to Aug/Sept.

OTHER INFORMATION.
Hospital pharmacists can support efficient flow by providing support around medicines optimisation within the ED by undertaking medicines reviews, medicines reconciliation and planning for discharge which result in avoiding admissions. Nottingham University Hospital has prioritised the patients the pharmacist should focus on including patients identified as taking any high risk or critical medicines, patients over the age of 65 admitted with a fall or collapse and patients diagnosed with acute kidney injury or chronic kidney disease. This has resulted in 1,434 interventions, 57% of which were categorised as having potential to cause serious or severe harm. The potential cost saving is £617,970 –£1,348,800 and the potential prevented in-patient stays is 345 bed days. The pharmacist has also had a significant impact on patients with Parkinson's Disease where it is critical that their medicines are taken at the correct time. Statistical significantly lower amounts of missed or delayed doses were observed in patients who had early pharmacist intervention, both during patients wait in ED (19.2% vs 72.3%, $P<0.05$) and their first 24 hours as in-patients (8.6% vs 34.9%, $P<0.05$).

With advanced clinical practitioner (ACP) training pharmacists are able to see a wider range of patients which will support other ED colleagues by ensuring effective and efficient use of the multidisciplinary team. Courses for ACP pharmacists are now available.

2. Reducing discharge delays by undertaking medicines reconciliation and preparing for discharge on admission (Improving flow through the system)

WHAT IS THE CHALLENGE?
Patients wait many hours for a take home letter and medicines which delays the time of their discharge. This causes unnecessary delays for both the patient concerned and patients in ED by reducing the availability of beds for patients with a decision to admit.

WHAT CAN BE DONE?
Completely integrating the pharmacy team with the ward team and using near patient dispensing significantly reduces these delays and improves quality. In East Lancashire Hospitals' NHS Trust they have implemented a Dedicated Ward Pharmacy (DWP) service. The pharmacist works on the same ward throughout their working day, participating in consultant-led ward rounds, ensuring medicines optimisation, medicines safety and antimicrobial stewardship occur. Together with the pharmacy technicians they complete medicines reconciliation on all patients, prepare the medicines sections of electronic discharge letters and ensure necessary medicines are available before discharge and refer eligible patients to their community pharmacist for post-discharge medicines support. On two pilot wards pharmacists are writing the entire discharge letter.

WHAT ARE THE RESULTS?
An analysis of the 10 wards where the DWP scheme has been implemented demonstrated:

- an annualised saving of £259,688 on drug costs from the 187 pilot ward beds.
- 18% reduction in readmissions with the same diagnosis in 28-days (20% reduction at 7-days). Extrapolated to Trust level, this equates to at least 1,116 fewer patients readmitted by 28-days with the same diagnosis.
- 2.2 day reduction in length of stay (at midnight) on six comparative pilot wards.
- A minimum of a 3% increase in discharges by lunchtime; a 16% reduction in patients discharged after 5pm attributed to pharmacy team co-ordination of ward discharge planning, with technicians creating medicine sections of 211 e-discharge letters in a four week period.

OTHER INFORMATION:
There has been an improvement in safety, length of stay has reduced, readmissions have reduced, drug expenditure has decreased, flow is improved with earlier discharges, and patient and staff experience is improved. The improvements in safety and length of stay can be traced to the nature and number of interventions recorded; the reduction in readmissions due to using the Refer-to-Pharmacy scheme to ensure eligible patients are referred to their community pharmacist for post-discharge medicines support. These results are being replicated in other hospitals such as Preston.

3. Reducing admissions and readmissions by supporting people in care homes

WHAT IS THE CHALLENGE?
Residents of UK care homes for the elderly fall on average two to six times per year.[1] In 2009[2] it was estimated that 25% of residents in care homes for the elderly were prescribed antipsychotics. One study showed antipsychotic dispensing increased from 8.2% before a person enters a care home to 18.6% after entering.[3] An estimated £24 million is lost every year due to medicine wastage in care homes across England alone.[4]

WHAT CAN BE DONE?
Pharmacists, as part of the multidisciplinary team, should have overall responsibility for medicines and their use in care homes. This will result in significant benefits to care home residents, care home providers and the NHS. Pharmacists, as experts in medicines use, can play a significant role in reducing the use of unnecessary and sometimes harmful medicines, particularly through regular reviews of the efficacy and safety of medicines taken by residents.

WHAT ARE THE RESULTS?
If a clinical medicines review service involving patients, their representatives or carers, was to be commissioned for all 405,000 care home residents over the age of 65, the base cost of the pharmacist and the medication review would be approximately £13.4m-£15.8m. The potential costs savings to the NHS, if this service were to be delivered across all care homes in England, are estimated at £135 million (£65 million from medicines being stopped, started or changed and £70 million from reduced hospital admissions).[5] This is roughly £3 million per STP.

OTHER INFORMATION:
Many of the Enhanced Care in Care Home vanguards are utilising the skills and knowledge of pharmacists. An example of this in practice can be found at https://www.pcc-cic.org.uk/article/meds-optimisation-pilot-wins-widespread-backing-bucks

4. Reduce medicine risk by supporting patients when they transfer between different care settings

WHAT IS THE CHALLENGE?
There is a substantial body of evidence that shows when patients move between care providers the risk of miscommunication and unintended changes to medicines remain a significant problem. More than 90% of elderly medical patients will have a change to their medicines during an admission to hospital. It has been reported that between 30% and 70% of patients have either an error or an unintentional change to their medicines when their care is transferred.

WHAT CAN BE DONE?
When community pharmacists are included as part of the referral pathway they provide a pharmaceutical consultation and counselling post-discharge to ensure changes to a person's medicines are known and acted upon in order to improve medicines safety and efficacy when they return to their home.

WHAT ARE THE RESULTS?
Those patients who received a community pharmacist follow-up consultation had statistically significant lower rates of readmissions and shorter hospital stays than those patients without a follow-up consultation.[5]

OTHER INFORMATION:
East Lancashire Hospitals NHS Trust have also developed a scheme and more information can be found at www.elht.nhs.uk/refer. This scheme is also showing promising results with a reduction of 1% in readmissions.

5. Improving the physical health for patients with severe mental illness (SMI)

WHAT IS THE CHALLENGE?
When treating individuals with SMI, which includes schizophrenia, bipolar affective disorder and schizoaffective disorder, it's natural to think foremost about their mental health. But these individuals are also at some of the greatest risk of poor overall health and premature mortality.[6] Striking figures show that SMI patients die on average 20 years earlier than the general population due to preventable physical health problems – a life expectancy similar to the 1950's.[7,8,9] Evidence suggests CVD is the leading cause of death in individuals with SMI. A combination of factors, including the side effects of anti-psychotic medication, lifestyle and difficulty accessing mainstream health services can all contribute to this decreased life expectancy.

WHAT CAN BE DONE?
Leicestershire Partnership NHS Trust developed a pharmacist led service to ensure that individuals with SMI received the relevant screening and related interventions for cardiometabolic disease. The aims of this service were to (i) improve the physical health of people with serious mental illness through screening and early identification of cardiometabolic risk factors, and, (ii) improve subsequent access to information and to services to support risk reduction strategies. The steps taken to achieve these outcomes were based on a centralised service (based within the pharmacy department) which: (i) improved physical health assessment processes; (ii) improve mechanisms for recording and monitoring physical health assessments; (iii) established a physical health record to improve communication of physical health risk factors and support shared decision making about access to interventions; (iv) implemented educational materials; (v) integration of the process as part of everyday care. Core to this work is reminders and follow up and a clinical screen, including CVD risk calculation, undertaken by a specialist mental health pharmacist.

Please also see the following document for further tips https://www.rcpsych.ac.uk/pdf/LPHR%20toptentips%20CQUIN.pdf

An automated system that does not rely on an individual remembering to carry out a test is the optimum system and has been critical to the success of the project.

WHAT ARE THE RESULTS?
The trust developed the pharmacist led service as part of a national CQUIN (a NHS England quality improvement an innovation scheme); the focus of this was progressively rolled out focusing initially on inpatient care and then to include early intervention and then community mental health teams. The outcomes measure was the percentage of individuals with SMI who were screened and received any related interventions as appropriate.

Year	Inpatient	Early Intervention	CMHT
2014/15	87%	–	–
2015/16	99%	95%	–
2016/17	100%	97%	87%

OTHER INFORMATION:
There is much that pharmacists can do to support patients with mental health conditions including ensuring that the medicines prescribed are appropriate for the person. For example Sunderland Community Learning Disability team, part of Northumberland Tyne Wear NHS Foundation Trust, have developed two clinic models to begin to undertake reviews of people with a learning disability taking powerful psychotropic drugs (antipsychotics, mood stabilisers etc) for the control of challenging behaviour. More information can be found at https://fabnhsstuff.net/2017/01/25/stopping-overmedicating-people-learning-disability/

More examples of how pharmacists are improving patient flow through the system can be found in this briefing published by the Emergency Care Improvement Programme https://improvement.nhs.uk/uploads/documents/optimising-medicines-discharge-to-improve-patient-flow-RIG_holhrdD.pdf

ROYAL
PHARMACEUTICAL
SOCIETY
England

REFERENCES

1. Rubenstein L Z. Josephson K R. Osterweil M D. (1996) Falls and Fall Prevention in the Nursing Home. Clinics in Geriatric Medicine 12(4): 881-902.
2. Banerjee S, 2009. The Use of antipsychotropic medication for people with dementia time for action. Report to the minister of State. http://www.rcpsych.ac.uk/pdf/Antipsychotic%20Bannerjee%20Report.pdf
3. Maguire, A., Hughes, C., Cardwell, C. & O'Reilly, D. Psychotropic medications and the transition into care: a national data linkage study. Journal of the American Geriatrics Society, 2013; 61: 215-221.
4. York Economics Consortium and University of London (2010) Evaluation of the Scale, Causes and Costs of Waste Medicines
5. http://www.rpharms.com/promoting-pharmacy-pdfs/care-homes-report.pdf
6. Chang C-K, Hayes RD, Perera G, et al. Life Expectancy at Birth for People with Serious Mental Illness and Other Major Disorders from a Secondary Mental Health Case Register in London. PLoS One. 2011; 6(5): e19590
7. Laursen TM, Wahlbeck K, Hallgren J, Westman J, Osby U, Alinaghizadeh H, et al. Life expectancy and death by diseases of the circulatory system in patients with bipolar disorder or schizophrenia in the Nordic countries. PLoS One 2013; 8: e67133
8. Roshanaei-Moghaddam B, Katon W. Premature mortality from general medical illnesses among persons with bipolar disorder: a review. Psychiatr Serv 2009; 60: 147–56
9. Weiner M, Warren L, Fiedorowicz JG. Cardiovascular morbidity and mortality in bipolar disorder. Ann Clin Psychiatry 2011; 23: 40–7.

Published by the Royal Pharmaceutical Society
66-68 East Smithfield
London
E1W 1AW
0845 257 2570